Health Care Finance and Public Health

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ABSTRACT

In a globalising world, public health is no longer limited to national health, but also to global health and health financing. In recent years, we have seen a decrease in health financing for health care, the full scope of this is unknown because data is limited and anecdotal. If this trend continues, experts believe it will have serious consequences for public health systems around the world. Despite the growing importance of health-care financing, there is little empirical evidence on its impact on public health, particularly health-care systems, this paper summarises the most recent discussions on the subject, It discusses the main forces driving health care finance and public health, as well as the implications for health systems, particularly the effects on access to health care, financing, and the health workforce. This paper also discusses how to define medical and health finance, as well as how to improve data collection in health care. It advocates for more scientific research to enable countries to reap the benefits of medical and health financing while limiting the potential risks to public health.

Key words: Health care, cost, hospitals, logistics, diseases, outbreaks, global health, health promotion, and awareness are some key words.

INTRODUCTION

One of the world's most pressing issues is how to finance and provide health care for the 1.3 billion poor people living in low- and middle-income countries. Many poor people lack access to effective and affordable drugs, as well as surgery and other interventions, owing to flaws in health-care financing and delivery. Although low- and middle-income countries bear 93 percent of the global disease burden, they account for only 11 percent of global health spending (US$ 2800 billion) (Preker, A S 2002).

For years, many low- and middle-income countries have attempted to skip the developmental steps required to achieve universal risk protection, Traditional public financing instruments, such as general revenues and social insurance, have been the preferred mechanism for this. Few have been successful in this approach. Estimates of the expenditure gap required to achieve universal access to health care for low-income people through such public financing mechanisms range from US$ 2550 billion to more than US$ 100 billion. In this context, despite its shortcomings, community financing is frequently the only viable option for providing some financial security and access to basic health services for the poor (Preker, A S 2002).

This paper summarises the findings of a large-scale collaborative study to assess the impact, community involvement's strengths and weaknesses in financial protection against illness costs and improving access to health care for poor rural populations and workers in the informal sector It investigates potential policies for addressing managerial, organisational, and institutional weaknesses in community financing, rather than attempting to replace them through direct government intervention, which has frequently failed (Preker, A S 2002).

Many countries around the world became acquainted with the term "global financial crisis" and its consequences over the last decade. The crisis first manifested itself in the economic sector, primarily in the United States of America and the United Kingdom. Trillions of dollars have been lost globally, according to estimates. Since that time, the crisis actually spread, primarily affecting Ireland, Iceland, as well as South-European and Asian countries, where revenue from exports and investment fell dramatically. In terms of health, the economy has a significant impact because poor socioeconomic conditions frequently result in inequalities in access to public or private resources, resulting in a decreased ability for productivity, power, and control (Ifanti, A. A).

The consequences of the global financial recession and the implementation of austerity measures in Greece created a difficult situation, the burden of which was not only visible in the economic field but also had a significant negative impact on the national health sector and social services. In turn, the government was unable to adequately support the public health sector and maintain the already deteriorating social services.

The impact of the financial crisis and austerity measures on the health sector, social services, and health care politics in Greece is examined here as a continuous barrier to public health. First and foremost, we intend to present the financial recession in the context of socioeconomic and public health care. Second, we will investigate the impact of the crisis on the Greek health sector in order to highlight the fact that policymakers should not overlook the unavoidable consequences of austerity and fiscal policies on health care in Greece (Ifanti, A.A et aal).

DEFINING HEALTHCARE FINANCE

What exactly is healthcare finance? It may surprise you to learn that there is no single answer because the definition of the term is largely determined by the context in which it is used. As a result, you should start by learning the scope and meaning of the term healthcare finance as it is used in this book. To begin, understand that healthcare finance is not about funding the healthcare system.

Healthcare financing is a distinct topic that deals with how society pays for the healthcare services it uses. This is a complex and politically charged issue that we do not address directly in this book, Of course, how healthcare is funded affects how hospitals and physicians are reimbursed for services, and thus has a significant impact on healthcare finance. The majority of users work in healthcare settings such as medical group practices, hospitals, home health agencies, or long-term care facilities. As a result, we focused on finance as it applies in health care organisations to create a book that provides the most value to its primary users. Of course, finance principles and practices cannot be studied in a vacuum; they must be grounded in the realities of today's healthcare environment, including how healthcare services are funded. Healthcare finance in health care organisations includes both accounting and financial management functions (see "Critical Concept: Healthcare Finance"). Accounting, as the name implies, is concerned with the financial recording of economic events that reflect an organization's operations, assets, and financing.

In general, the goal of accounting is to generate and disseminate useful information about an organization's financial status and operations to interested parties, both internal (managers) and external (investors). Whereas accounting provides a rational framework for measuring and assessing a company's financial performance and operations, financial management (also known

as corporate finance) provides the theory, concepts, and tools that enable managers to make better financial decisions. Of course, the distinction between accounting and financial management is hazy; certain aspects of accounting involve decision-making, and much of the application of financial management concepts necessitates the use of accounting data.

THE ROLE OF FINANCE IN HEALTH SERVICES ORGANIZATIONS

The primary role of finance in health care organisations, as in all businesses, is to plan for, acquire, and use resources in order to maximise the enterprise's efficiency (and value) (see "Critical Concept: Role of Finance"). As discussed in section 1.4 of this chapter, at larger organisations, the two broad areas of finance accounting and financial management are separate functions, though the accounting function is usually carried out under the direction of the organization's chief financial officer (CFO) and thus falls under the overall category of finance.

THE STRUCTURE OF THE FINANCE DEPARTMENT

The finance department's structure is determined by the type (e.g., hospital, medical practice) and size of the healthcare organisation. Large organisations typically structure their finance departments as follows. The chief financial officer is the head of the finance department (CFO), This person typically reports directly to the organization's chief executive officer (CEO) and is in charge of all finance activities. The CFO supervises two senior managers who assist in the management of finance activities: the comptroller and the treasurer.

The comptroller (also spelled "controller") is in charge of accounting and reporting activities such as routine budgeting, financial statement preparation, and patient account management. The treasurer is primarily in charge of capital acquisition and management (funds). In other words, the treasurer is responsible for raising funds for the organisation and ensuring that those funds are used effectively. Capital acquisition, cash and debt management, lease financing, financial risk management, and endowment fund management are examples of specific activities (in not-for-profits). The treasurer is generally involved in these activities. In large organisations, the comptroller and treasurer are supported by managers who are in charge of specific functions, such as the patient accounts manager who reports to the comptroller and the cash manager who reports to the treasurer. Many financial responsibilities are combined and assigned to one person in small businesses. In a small group practice, for example, the finance function is typically

managed by one person, often referred to as the business (practice) manager, who is assisted by one or more clerks.

HOSPITALS

The current economic situation of our country's public hospitals reflects the questionable viability of our country's health-care system. The total operating cost of hospital units is estimated to be made up of approximately 65 percent payroll expenses for all categories of staff, which are largely inelastic, and 35 percent operating costs (N. Polyzos, 2007). The latter are considered to be elastic in their overwhelming majority, with the key characteristic being supplies of all kinds (medicines, medical materials, chemical reagents, etc.), (hospital expenses and revenues), the expenses column does not include staff payroll, which accounts for the majority, because it is paid directly by the state budget. According to the Ministry of Finance's annual report data, NHS hospital payroll expenses totaled €2.24 billion at the end of 2006. Operating costs account for 82.19 percent of total hospital costs. Hospital supplies account for the majority of operating (elastic) costs and are the primary source of debt. At the end of 2007, the debt distribution was as follows: According to the analysis, 43 percent are medicines, 28 percent are medical materials, 12 percent are chemical reagents, 10 percent are Orthopaedic materials, and 8 percent are other. One of the primary causes of hospital debt (estimated1 at 35% of total debt) is that hospitals do not pay their suppliers immediately; as a result, they not only do not benefit from any price reductions on products during negotiations, but they also do not benefit from any price reductions on services, However, they are also charged for payment delays. The difference between actual and agreed-upon hospitalisation fees paid by insurance funds is also attributed to this lack of liquidity (N. Polyzos 1999, Yfantorpoulos 2006).

The actual daily operating cost per hospitalisation day is estimated to be three times that of the agreed-upon hospitalisation fee (K. Souliotis., G. Kyriakopoulos 2001, N. Polyzos 2007). Another issue is the long-delayed collection of hospitalisation fees from insurance funds, which is the primary source of revenue for hospital budgets. A large portion of such hospitalisation fees is collected in instalments over different fiscal periods, amounting to up to 90% of the total.

The remaining 10% is not paid in order to offset the central government's unpaid obligations to such funds. The aforementioned are structural operational issues of the broader health system and thus hospitals.

DIFFERENCES BETWEEN RICH AND POOR IN FINANCIAL PROTECTION AGAINST COST OF ILLNESS

In middle- and higher-income countries, a combination of general taxation, social insurance, private health insurance, and limited out-of-pocket user charges has emerged as the preferred instrument for health financing. In these settings, large segments of the population work in cities and in formal jobs. It is relatively simple to tax such workers at the source and to design health-care systems funded by government or payroll taxes.

However, policy options for financing health care at low-income levels are more limited. Low-income countries frequently have large populations in the rural and informal sectors, limiting their governments' effective taxation capacity. In middle- and high-income countries,

Large segments of the population work in cities and in formal employment sectors, and it is relatively simple to tax workers at the source and design health-care systems that are funded by government or payroll taxes. In most low-income countries, the formal urban employment sector is small in comparison to the rural and informal employment populations.

In these countries, such populations frequently lack effective collective arrangements for paying for health care or receiving protection from the cost of illness.

A similar set of issues arises during the pooling stage of health financing. Pooling necessitates some resource transfer from rich to poor, from healthy to sick, and from the economically active to the economically inactive. People on low incomes face severe financial hardship if they become ill in the absence of such pooling. Pooling is frequently fragmented along income groups, preventing effective cross-subsidies between higher and lower income groups. Cross-subsidies may also be avoided when fragmentation is based on professional categories; for example, separate pools may exist in the same region for workers and farmers. When faced with a severe illness that necessitates hospitalisation, many households become destitute. At low-

income levels, the proportion of the population covered by risk-sharing arrangements is comparatively low in the face of overwhelming demand and very limited supply.

Many governments find it difficult to ration health care so that public funds are directed toward the poor. In many low-income countries, the rich often benefit more than the poor from government subsidies and spending. Public policies that, in theory, provide health care to the entire population may unwittingly divert scarce health-care resources away from the poor and toward segments of the population with greater political clout in the health-care system (Preker, A S 2002).

Determinants of financial protection in community financing

Members of community financing schemes reported higher use of health care and lower out-of-pocket expenditures in three of the surveys. This supported the original hypothesis that risk pooling and prepayment reduced financial barriers to health care. Furthermore, even when individuals were members of a community financing scheme, being poor and unable to pay additional out-of-pocket costs remained a significant barrier to access (Preker, A S 2002.

CURRENT CHALLENGES

The American College of Healthcare Executives (ACHE) has conducted an annual survey of CEOs regarding the most pressing concerns of healthcare executives in recent years. Since the survey's inception in 2002, financial concerns have topped the list of challenges every year. When asked to rank their specific financial concerns in 2015, CEOs named the transition from fee-for-service to a value-based payment system as their top priority, with adequate Medicaid reimbursement and bad debt also near the top of the list. In the same way that ACHE surveyed its CEO members, the Healthcare Financial Management Association surveyed CFOs in 2017 about their future concerns.

Their most pressing issue was the need for increased technological investments to improve revenue cycle management. Aside from increased budgets, CFOs emphasised the importance of better leveraging technology to connect clinical and financial opportunities in order to optimise performance. Another major source of concern among CFOs was the rise in uncompensated care as patients take on more financial responsibility through high-deductible health plans. These

surveys, taken together, confirm that finance is of primary importance to today's healthcare executives. The rest of this paper is devoted to assisting and resolving these issues.

CONCLUSIONS

Too few countries have all of the key policies in place to ensure that palliative care is accepted. Some healthcare services remain prohibitively expensive in far too many countries. Only a small portion of the required workforce has been educated and trained, and there are still too few providers and teams in place to meet the population's needs. The willingness of governments to reallocate acute care resources to palliative care as a proactive strategy to better manage health care costs is critical to the future growth of health care finance and public health care. This is a part of the solution to a country's health-care issues,

There are numerous reasons why health care finance should grow and thrive in the coming decades, including the global population's ageing, the increased burden of noncommunicable disease, and, most importantly, to reduce the unacceptable global burden of suffering.

There are many challenges and barriers, but the work continues, and the 2014 World Health Assembly to strengthen health care financing care integration provides an impetus for national governments to develop and improve public health finance integrated into their national health systems.

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